

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00666

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County Howard
 City or town Waterloo, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Dead on arrival at Regional Hospital,
 How long in hospital or institution? Fort Meade, Maryland.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Relay
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1803 Center St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

WILLIAM HERBERT ELLIOT

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced -

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 14 February, 1927 6.(c) If alive, give age years

8. AGE: Years 18 Months 10 Days 26 If less than one day
 hrs. min.

9. Birthplace
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Trooper C. F. Beland Waterloo State PoliceAddress Waterloo, Md.

17. Removal Date thereof Jan. 9, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory (Body removed by U. S. Naval Authorities)
 Location

18. Funeral director George W. Davis

Address

19. 9 Jan. 19 46 Frank J. Tollison
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 JANUARY 19 46 at 0625A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Seen dead only 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Possible broken neck

DURATION

Due to Auto accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9 Jan 46

Where did injury occur? Waterloo Howard Md
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Balto-Washing HighwayMeans of injury Auto accident Injured at work? No.23. SIGNATURE Maurice Goldberg 1st Lt MC

MAURICE GOLDBERG

M. D. or other

Address Regional Hospital, Ft. Meade, Md. Date signed 9 Jan 46

RECEIVED

JAN 16 1946

BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

CERTIFICATE OF DEATH

Reg. Dist. No. 006197 191

1. PLACE OF DEATH:

County HOWARD
City or town NEAR ELLICOTT CITY
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs 5 months
Hospital, institution, or street address where death occurred:
PINEL CLINIC - HOWARD COUNTY
How long in hospital or institution? 4 yrs - 5 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MARYLAND County BALTO CITY
City or town BALTO CITY
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5700 PIMLICO ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

KATHERINE M. GRACE

3.(b) Social Security Number

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED
6.(b) Name of husband or wife JAMES W. GRACE
7. Birth date of deceased (mo., day, yr.) NOVEMBER 22 1888 8.(c) If alive, give age _____ years
8. AGE: Years 57 Months 1 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace BALTIMORE, MARYLAND
(Town, county, and state)
10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name Thomas Donohue
13. Birthplace Ireland
14. Maiden name Reddington
15. Birthplace Ireland

16. Informant DAUGHTER MRS MARIE HANLEY
Address 5700 PIMLICO ROAD BALTO. MD

17. Burial Burial Date thereof 1/4/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory New Cathedral Cem.
Location Balto., Md.
WM. J. TICKNER & SONS

18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19. 1/2 19 46 A.W. Hedrich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 1st 1946 at 11:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOVEMBER 1st 1945 to JANUARY 1st 1946
and that I last saw h.e. alive on JANUARY 1st 1946

Immediate cause of death CEREBRAL HEMORRHAGE DURATION 1 DAY

Due to _____
Due to _____

Other conditions PSYCHOSIS WITH CEREBRAL ARTERIOSCLEROSIS
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE Helmuth Trager M.D. M. D. or other
Address Ellicott City, Md Date signed 1/11/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Diat. No. 00668 193

1. PLACE OF DEATH:

County Howard
 City or town Rural Florence Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Howard Co Md
 City or town Rural Florence Md
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Emma Hawkins

3.(b) Social Security Number

4. Sex Female 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife _____

7. Birth date of
 deceased (mo., day, yr.) Feb 9 - 1862

6.(c) If alive, give age _____ years

8. AGE: Years 83 Months 11 Days 8 If less than one day
 _____ hrs. _____ min.

9. Birthplace Montgomery Co Md
 (Town, county, and state)

10. Usual occupation Housewife11. Industry or business None12. Name Joseph H Claggett13. Birthplace Md14. Maiden name Mary Ann Higgins15. Birthplace Md16. Informant Hiram E HawkinsAddress Mt Airy Md

17. Burial, cremation, or removal. Which? Burial Date thereof Jan 20, 1946
 (month) (day) (year)

Cemetery or crematory Daytonville MdLocation Montgomery Co Md18. Funeral director Robt W. BarberAddress Daytonville Md

19. Date rec'd by registrar Jan - 20 46 E. Paul Merwin
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1946 at 12:30 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
June 1940 to Jan. 17 1946
 and that I last saw him alive on January 16, 1946

Immediate cause of death
senility

DURATION
5 yrsDue to Arterio-sclerosis2 yrs

Due to _____

Other conditions dry gangrene of right
 foot and lower 1/3 leg
 (Include pregnancy within 3 months of death)

3 mo.Major findings of operations none

Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (whore?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Stanley Crabill

M. D. or other

Address Mt Airy, Md Date signed 1/18/46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

FEB 5 1946

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

Reg. Dist. No. 191

00669

1. PLACE OF DEATH:

County HowardCity or town Hy. blund
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Hy. blund
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Howard D Johnson

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Bertha S Johnson7. Birth date of deceased (mo., day, yr.) May 3, 18648. AGE: Years 81 Months 8 Days 18 If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Lorenzo Johnson13. Birthplace Ind.MOTHER 14. Maiden name unknown15. Birthplace IL16. Informant Mrs. Bertha S JohnsonAddress Hy. blund Ind17. Burial Date thereof 1-24-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lutheran ChapelLocation Clarksville Md18. Funeral director F. C. HigginbothamAddress Ellicott City Md19. Jan. 23, 1946 John B. Loughran
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21, 1946 at 8:57 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 20, 1946 to Jan. 21, 1946and that I last saw him alive on January 20, 1946Immediate cause of death CerebralhemorrhageDue to general arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work?

23. SIGNATURE John B. Loughran M. D. or otherAddress Sandy Spring, Md Date signed Jan. 23, 1946

RECEIVED
JAN 26 1946
BUREAU V.E.

RECEIVED
JAN 26 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 615

CERTIFICATE OF DEATH

Reg. Dist. No.

0067995

1. PLACE OF DEATH:

County Howard
 City or town Jessups R.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard
 City or town Jessups R.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex F 5. Color or race C. 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife William Kelly
 6. (c) If alive, give age 63 years
 7. Birth date of deceased (mo., day, yr.) 1888
 8. AGE: Years 58 Months Days It less than one day
 hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1946, at 1 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 1945 to Jan 24 1946
 and that I last saw him alive on Jan 20 1946
 Immediate cause of death Diabetic Insulin (#59)
 DURATION 5 yr
 Due to
 Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide
 Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Robert J. McCombs, M.D.
 Address 402 Main St. Jessups Md. Date signed 1/25/46

9. Birthplace Highland, Howard Co. Md.
 (Town, county, and state)
 10. Usual occupation HW at home
 11. Industry or business
 12. Name John Wesley Bentley
 13. Birthplace Md.
 14. Maiden name Mary Ann Doney
 15. Birthplace Md.
 16. Informant William Kelly
 Address Jessups Md.
 17. Burial Date thereof 1-26-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Stephen's Chapel
 Location Highland Md
 18. Funeral director F.C. Higginbottom
 Address Fellsmere City Md
 19. 1/25/46 Registrar Frank Shipley
 (Date rec'd by Registrar)

AFRICAN LEADER

NO CONTENT

NOTICE: THIS JOURNAL

RECEIVED

JAN 29 1946

BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

00671

Reg. Dist. No. 195

1. PLACE OF DEATH:

County Howard
City or town Savage
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Howard
City or town Savage Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Anna Rebecca Lutholtz

3. (b) Social Security Number

4. Sex Female 6. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife 7

7. Birth date of deceased (mo., day, yr.) Feb - 4 - 1867 6. (c) If alive, give age _____ years

8. AGE: Years 78 Months 10 Days 30 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Noah B. Lutholtz

13. Birthplace Va.

14. Maiden name Betty B. Mangold

15. Birthplace Sh. Va.

16. Informant Margaret Lutzer

Address Savage Md

17. Buried Date thereof Jan - 5 - 46
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Johns

Location Redland Md

18. Funeral director Lloyd Kauer

Address Laurel Md

19. 1/4/46 Frank Shipley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 19 46 at 4:10 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 19 43 to January 3 19 46 and that I last saw him alive on January 3 19 46

Immediate cause of death Chronic Myocarditis

DURATION

5 years

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Robert S. McConney M.D.

Address Laurel Md Date signed 1/3/46

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 7 1946
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 193

1. PLACE OF DEATH:

County HowardCity or town Crooksville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 56 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Hattie L. Parker

3. (b) Social Security Number

##4. Sex F.5. Color or race W.6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Joseph L. Parker6. (c) If alive, give age 1 years7. Birth date of deceased (mo., day, yr.) March 14, 18708. AGE: Years 75 Months 9 Days 28 If less than one day

hrs. min.

9. Birthplace Crooksville, Md.

(Town, county, and state)

10. Usual occupation House work

11. Industry or business

12. Name John G. Howard13. Birthplace Md.14. Maiden name Henrietta Ann Smith15. Birthplace Md.16. Informant Mrs. H. P. BandyAddress 711 E. Symmes St. Crooksville17. Burial Date thereof Jan. 12, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bushy Park CemeteryLocation Crooksville, Md.18. Funeral director C. Harry ViewAddress Crooksville, Md.19. Jan. 11, 1946 C. Harry View

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HowardCity or town Crooksville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9th 19 46 at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-10-45 19 45 to 1-9-46and that I last saw him alive on 1-9-46 19 46

Immediate cause of death

Mitral Insufficiency

DURATION

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. F. Maloney MD

M. D. or other

Address Calonsville, Md. Date signed 1/9/46

RECEIVED

FEB 5 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

CERTIFICATE OF DEATH

Reg. Dist. No. 00673 195

1. PLACE OF DEATH: *Howard*
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *Life*
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....*Maryland* County.....*Howard*
City or town.....*Savage*
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
Sarah Belle Pickett

3. (b) Social Security Number

4. Sex *F* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *Married*

B. (b) Name of husband or wife *L. N. Pickett*

7. Birth date of deceased (mo., day, yr.) *June 11-1869* B. (c) If alive, give age *75* years

8. AGE: Years *96* Months *6* Days *25* If less than one day
.....hrs.min.

9. Birthplace.....*Maryland*
(Town, county, and state)

10. Usual occupation.....*Housewife*

11. Industry or business.....

12. Name.....*Joseph P. Wheeler*

13. Birthplace.....*MD*

14. Maiden name.....*Margaret Dove*

15. Birthplace.....*MD*

16. Informant.....*L. N. Pickett*

Address.....*Savage MD*

17. (Burial, cremation, or removal, Which?) *Burial* Date thereof *Jan-8-46*
(month) (day) (year)

Cemetery or crematory.....*Savage MD*

Location.....*Savage MD*

18. Funeral director.....*Edgar Kaiser*

Address.....*Savage MD*

19. *1/7/46* 19.....*Frank Shipley*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Jan. 6th* 19.....*46* at.....*130 a.* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Dec. 5th* 19.....*45* to *Jan. 6th* 19.....*46*

and that I last saw him/her alive on *Jan. 5th* 19.....*46*

Immediate cause of death.....*Cerebral embolism*

Due to.....*Chr. Myocarditis*

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*Frank Shipley, M.D.*
Address.....*Savage, MD* M. D. or other.....
Date signed.....*1/7/46*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 9 1946
BUREAU V.S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

00674

1. PLACE OF DEATH

County Howard Registration Dist. No. 239 195
 Village or City Colesville near Laurel Md. St. _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)
 Length of residence in city or town where death occurred 65 yrs. _____ mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

Ediston Snell If U. S. Veteran, specify WAR _____
 (a) Residence: No. Colesville Laurel R. F. D. 2 Ward. _____
 (Usual place of abode) _____ If nonresident give city or town and State _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____		
6. DATE OF BIRTH (month, day, and year) <u>Unknown</u>		
7. AGE <u>About 70 yrs</u>	Years _____ Months _____ Days _____	If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Unknown</u>		11. Total time (years) spent in this occupation _____
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>Unknown</u>		
10. Date deceased last worked at this occupation (month and year) _____		

12. BIRTHPLACE (city or town) Howard Co. near Laurel Maryland
 (State or country) _____

13. NAME Henry Snell

14. BIRTHPLACE (city or town) Howard Co. Md.
 (State or country) _____

15. MAIDEN NAME Sarah Tibbs

16. BIRTHPLACE (city or town) Howard Co. Maryland
 (State or country) _____

17. INFORMANT Carrie Tibbs
 (Address) Colesville, near Laurel Md.

18. BURIAL, CREMATION, OR REMOVAL
 Place Colesville Date Jan 15, 1946

19. UNDERTAKER Ridgely Selby
 (Address) 401 North Ave. Laurel Md.

20. FILED Jan 14, 1946 M. Brashear
 Registrar _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan 10, 1946
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 27, 1944 to Jan 1, 1946

I last saw him alive on Jan 1, 1946; death is said to have occurred on the date stated above, at _____ m.

THE PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Cerebral hemorrhage 10 days
hypertension 10 yrs

Other Contributory Causes of importance: Arteriosclerosis 10 yrs

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of Injury _____, 19 _____

Where did injury occur? _____

(Specify city or town, county and State)
 Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of Injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) J. M. Warren M. D.

(Address) Laurel Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis

Date of onset

1915

Chronic interstitial nephritis

1921

Cerebral hemorrhage

July 5, 1927

Other contributory causes of importance:

Gallstones

May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy

Date of onset

1 week ago

Run over by street car

1 week ago

Peritonitis

3 days ago

Other contributory causes of importance:

Gastroenteritis

1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

Reg. Dist. No. 00675 190

1. PLACE OF DEATH:

County.....Howard
 City or town.....Elbridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....4 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....Maryland County.....Howard
 City or town.....Elbridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....1914 Railroad ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Nellie Priscilla Weigandt.

3. (b) Social Security Number

None

4. Sex.....Female
 5. Color or race.....White
 6.(a) Single, married, widowed, or divorced.....Widowed
 6.(b) Name of husband or wife.....Robert Lee Weigandt
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.).....June 23, 1867
 8. AGE: Years.....78 Months.....7 Days..... It less than one day..... hrs..... min.

9. Birthplace.....Elbridge Md
 (Town, county, and state)
 10. Usual occupation.....Homemaker

11. Industry or business

FATHER
 12. Name.....Philip Harman
 13. Birthplace.....A. A. Co. Md.
 MOTHER
 14. Maiden name.....Liza Jane Bushington
 15. Birthplace.....Howard Co. Md

16. Informant.....Mrs Mollie Smith
 Address.....1914 Railroad ave, Elbridge, Md.

17. Burial (Burial, cremation, or removal. Which?).....Burial Date thereof.....Jan 25, 1946 (month) (day) (year)
 Cemetery or crematory.....Zion Cemetery
 Location.....Dorsey Md.

18. Funeral director.....L. Lester Garp
 Address.....5523 main st Elbridge Md

19. Jan 23 46 (Miss) E. R. Williams (Date rec'd by registrar) (Signature of registrar) Local

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Jan 23 1946 at 1:20 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1945 to Jan 23 1946 and that I last saw him alive on Jan 22 1946
 Immediate cause of death.....Broncho-pneumonia
 Due to.....Chronic myocarditis
 Due to.....Decapitated
 Other conditions.....General arteriosclerosis
 (Include pregnancy within 8 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE.....E. R. Williams M. D. or other
 Address.....5523 main st Elbridge Md Date signed.....Jan 25 46

RECEIVED
JAN 25 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00676

Reg. Dist. No. 195

1. PLACE OF DEATH:

County HowardCity or town Savage
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Savage
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Albert C. Williams

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Ellen P. Williams7. Birth date of deceased (mo., day, yr.) April 22 - 1870 6. (c) If alive, give age 40 years8. AGE: Years 75 Months 8 Days 20 If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Electrician11. Industry or business Retired12. Name unknown13. Birthplace "14. Maiden name "15. Birthplace "16. Informant Mrs. Ellen P. WilliamsAddress Savage Md17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof June 15 - 46
(month) (day) (year)Cemetery or crematory SavageLocation Savage Md18. Funeral director Robert LauerAddress Laurel Md19. 1/14/46 19 Shankshley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12th 1946 at 6³⁰ P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 37 1946 to Jan. 12th 1946
and that I last saw him alive on Jan. 12th 1946Immediate cause of death Sanguine of left legDue to arterio-sclerosisDue to Cerebral Haemorrhage with hemiplegiaOther conditions "

(Include pregnancy within 3 months of death)

Major findings of operations "

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Shankshley M. D. or other U.S.Address Savage, Md. Date signed 1/14/46

DURATION

5 days8 yrs.8 yrs.

RECEIVED

JAN 16 1945

BUREAU V. R.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: *Howard Co. Eastern Tunnel Home*(c) Hospital or institution: *Elliott City*

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *3/25*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1609 Entaw Place*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Arnold O. Zengler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *11/16/1894*

8. AGE: Years Months Days If less than one day

*51 1 27 hr. min.*9. Birthplace *Princeton Ind.*

(Town, county, and state)

10. Usual Occupation *Boiler maker*11. Industry or business *Chicago Bridge-Const. Co.*12. Name *John Zengler*13. Birthplace *Ind.*14. Maiden Name *Sara Heiman*15. Birthplace *Ind.*16 (a) Informant *Sara A. Zengler*(b) Address *1609 Entaw Place*17 (a) *Funeral* (b) Date thereof *Jan. 16-46*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Oak Hill Cemetery*Location *Indiana*18 (a) Funeral director *F. B. Wappeler*(b) Address *1609 Entaw Place*19 (a) (b) *Huntington William*

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *January 12, 1946* at *1 A.* M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH *Fracture of neck,**Fracture of Pelvis*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury *1-12-46* *110 A.* M.(b) Where did injury occur *Wash. Blvd. near**Waterloo, Howard Co.*

Did injury occur at home, on farm, industrial place, in public

place? *Public* While at work? *no*(d) Means of injury *Pedestrian struck by*23. Signature *Robert Lee Graham* M.D.Date signed *Jan 12 1946* Medical Examiner.